MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04580

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH

County: Anne Arundel

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A A.

City or town: Glendale

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earnest Hamilton Ady

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Susan G. Ady

6.(c) If altre, gire age: years

7. Birth date of deceased (mo., day, yr.): May 29 - 1875

8. AGE: Years: 73 Months: 11 Days: 21 If less than one day: hrs. min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: W. S. Mayhew Address: Friendship Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: 5/23/48 (month) (day) (year)

Cemetery or crematory: Mt. Olivet

Location: Baltimore Md.

18. Funeral director: S. H. Hines Co.

Address: Washington D. C.

19. 5-21 48 (Date rec'd by registrar) 19 B.M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1948 at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2, 1948 to May 21, 1948 and that I last saw him alive on May 21, 1948

	DURATION
Immediate cause of death: Lobar Pneumonia	7 days
Due to: Old Injury	3 yrs.
Due to: Senility	
Other conditions: Emaciation	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Johnson M.D. M. D. or other

Address: Headpiece Md. Date signed: 5/24/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

04581

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Crumpton
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R F D # 3 Box 856
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Barden

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Ernest J. Barden

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 4, 1861

8. AGE: Years	Months	Days	If less than one day
87	1	16	..... hrs. ..... min.

9. Birthplace: England
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Fred John Barden

Address: R F D - 3 Box 856

17. Burial, cremation, or removal. Which?: Removal Date thereof: 5/21/48 (month) (day) (year)

Cemetery or crematory:

Location: Lynn, Massachusetts

18. Funeral director: John M. Taylor & Son

Address: Annapolis

19. (Date rec'd by registrar) May 21 19 48

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 19 48, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 19 48, to May 20 19 48, and that I last saw h.er alive on May 20 19 48

Immediate cause of death	DURATION
Arteriosclerotic cardio-vascular disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: E. Peyton Ritchings, M.D. M. D. or other

Address: Annapolis, Md. Date signed: May 20/1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coffee stage is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04582

170 C

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Arnold

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Ritchie Highway

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A A Co

City or town: Arnold

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jessie C. Beidleman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 9th 1886

8. AGE:	Years	Months	Days	If less than one day
	62	1	11	...hrs. ...min.

9. Birthplace: Scranton Penna. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER — 12. Name: Franklin A. Beidleman

13. Birthplace: Bloomsburg Pa.

MOTHER — 14. Maiden name: Almaretta Ameraman

15. Birthplace: Danville Pa.

16. Informant: Fred L. Lemming

Address: Arnold, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/22/48 (month) (day) (year)

Cemetery or crematory: W. Orange

Location: N. Jersey

18. Funeral director: John M. Taylor

Address: Annapolis

19. May 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1948 at 10 P. M

21. I CERTIFY that death occurred on the date above stated; ~~that I last saw him alive on~~ from Postmortem Examination to May 20 1948 ~~and that I last saw him alive on~~

Immediate cause of death	DURATION
Compound Fracture of Skull	sudden
Multiple lacerations of body	
Compound Fracture left lower leg	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 5-20-48

Where did injury occur? Arnold (City or town) A.A. (County) Md (State)

Injured at home, farm, industry, public place (where?) Ritchie Highway

Means of injury: Hit and run auto Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner M. D. or other

Address: Annapolis, Md. Date signed 5-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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04583

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Millersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred: Whitney's Landing Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town (If outside city or town limits, write RURAL and give nearest town)
Street No. Same
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bernard Berends

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of ~~husband~~ or wife Annie Hellmer
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) Nov. 12 - 1869.

8. AGE: Years 78 Months 6 Days 4 If less than one day hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Captain (Tug boat)

11. Industry or business

FATHER
12. Name Heinrich Berends.
13. Birthplace Germany

MOTHER
14. Maiden name Albertine Roepke
15. Birthplace Germany.

16. Informant Mrs. Carrie Jaffon (daughter)
Address Millersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/19/48 (month) (day) (year)
Cemetery or crematory Mount Carmel Cemetery
Locaiion Baltimore, Maryland

18. Funeral director HENRY SANDER & SONS, INC.
Address NORTH AVE. & BROADWAY

19. 5/19/48 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1948 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1947, to May 1948
and that I last saw him alive on May 6 1948

Immediate cause of death	DURATION
Cerebral thrombosis	
sclerosis	3 years
Due to Senility	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Paulen M.D.
M. D. or other
Address Glen Burnie, Md. Date signed 5/16/48

VS-A16 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04584

107

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 hrs 30 min.
Hospital, Institution, or street address where death occurred:
Johnsons' Clinc- 40 Northwest Street
How long in hospital or institution? 13 hrs 30 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Shady Side, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. Shady Side, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: Baby Blunt

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): April 30, 1948

8. AGE: Years | Months | Days | If less than one day: 13 hrs. 30 min.

9. Birthplace: Annapolis, Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER
12. Name: Edward Blunt
13. Birthplace: Churchton, Md. Anne Arundel

MOTHER
14. Maiden name: Ida Dennis
15. Birthplace: Shady Side, Anne Arundel Co. Md.

16. Informant: Julius Dennis
Address: Shady Side, Anne Arundel Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 3, 1948 (month) (day) (year)
Cemetery or crematory: St. Matthews Cemetery
Location: Shady Side Anne Arundel Co. Md.

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. May 3 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1948 19 48 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1948 to May 1, 1948
and that I last saw her alive on May 1, 1948

	DURATION
Immediate cause of death: Pneumonia, Broncho	13 hrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ———
Means of injury: ——— Injured at work?

23. SIGNATURE: Herbert H. Johnson M.D. M. D. or other
Address: 40 Northwest St Annapolis Md. Date signed 5/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b 04585 22

CERTIFICATE OF DEATH

Reg. Dist. No. 687

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups, Maryland.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? In institution 2 months
Hospital, institution, or street address where death occurred:
In Hospital 30 days
How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Maryland House of Correction
(If rural, give LOCATION)
2.(a) If veteran, name war: - - - (Formerly Pvt. Marines)

3.(a) FULL NAME: JOHN BONDNO

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1884

8. AGE: Years	Months	Days	If less than one day
64	3	23	- - hrs. ..... min.

9. Birthplace: Austria (Town, county, and state)

10. Usual occupation: - - - -

11. Industry or business: - - - -

FATHER
12. Name: Unknown
13. Birthplace: Austria

MOTHER
14. Maiden name: Not known
15. Birthplace:

16. Informant: MHC records
Address:

17. Burial. (Burial, cremation, or removal. Which?) Date thereof: May 18 1948 (month) (day) (year)
Cemetery or crematory: Cherry Hill
Location: Jessup Md
18. Funeral director: W F L Collins
Address: Jessup Md
19. May 17 1948 (Date rec'd by registrar) Clara Hasluh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1948 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 9, 1948 to May 8, 1948 and that I last saw him alive on May 8, 1948

Immediate cause of death: Congestive heart failure — DURATION: 1 mo.

Due to: Mitral insufficiency.

Due to: - - - -

Other conditions: - - - -

(Include pregnancy within 3 months of death)

Major findings of operations: - - - -

Date of op.: - - -

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - - - - Date of: - - -
Where did injury occur? - - - - (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John A Clark M.D.
John A. Clark, M.D., M. D. or other
Address: MHC., Jessups, Md. Date signed: 5-8-48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

CERTIFICATE OF DEATH 1634

Registered No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: H.H.C. Brooklyn
(a) Baltimore City, Maryland
(b) Street address 404 Church Street
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days) .....
(e) Length of stay in Baltimore (yrs., mos., or days) .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Brooklyn
(If outside city or town limits, write RURAL and give town)
(d) Street No. 404 Church St.
(If rural give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3 (a) FULL NAME Anna T. Booth

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
female	white	married

6 (b) Name of husband ~~or wife~~ Harry Booth
6 (c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1898

8. AGE: Years	Months	Days	If less than one day
50			..... hr. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual Occupation housewife
11. Industry or business

FATHER
12. Name James Kuntz
13. Birthplace Czechoslovakia

MOTHER
14. Maiden Name Anna Najek
15. Birthplace Czechoslovakia

16 (a) Informant Mrs. Mary L. Michael-sister
(b) Address 964 N. Collington Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5-29-48 (month) (day) (year)
(c) Cemetery ~~or crematory~~ Holy Redeemer
Location Belair Rd. Balto. Md.

18 (a) Funeral director Shimunek Funeral Home
(b) Address 2601 3-5 E Madison St.

19 (a) ..... (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1948, at 5:45 P.M.

21. I certify that I took charge of the remains described above, held an Inquest & inquiry thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation due to carbon monoxide poisoning

Due to .....

Other Conditions .....

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 5-25-48 at 4:45 P M.
(b) Where did injury occur? 404 Church St.
(c) Did injury occur at home, on farm, industrial place, in public place? home While at work? n.a.
(d) Means of injury? Jumping gas [illegible]

23. Signature ..... M.D.
Medical Examiner.
Date signed 5-26-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04587

932

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. ✓

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Carrs Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred: Carrs' Beach near Annapolis, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For stillborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Carrs Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. Carrs' Beach near Annapolis
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lizzie Chute Butler Brashears

3.(b) Social Security Number: None

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife:
6.(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): (Unknown) 1900
8. AGE: Years: 48 Months: Days: If less than one day: hrs. min.
9. Birthplace: Annapolis, Maryland A.A.Co.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margret Berry
15. Birthplace: Anne Arundel Co.

16. Informant: Margret Smith
Address: Parole, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 22, 1948 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. May 21 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1948 at 11 50 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~Most recent contact was~~ Post mortem Examination 19 ~~and that I last saw him alive on~~ May 19 1948

	DURATION
Immediate cause of death	
Due to: Acute Cardiac Failure	Sudden
Due to: Arterio-sclerotic heart disease	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Carey M.D. Deputy Medical Examiner M. D.
Address: Annapolis Md. Date signed: 5/19/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04588

836

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 52 Calvert St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ellen Brooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): December 28th 1882

8. AGE:

Years	Months	Days	If less than one day
65	4	29	...hrs. ...min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: Samuel W. Brooks
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Sarah E. Brady
15. Birthplace: Baltimore Md.

16. Informant: Mrs. Robert C. Bowen
Address: Calvert St. - Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 48 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. May 29, 19 48 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 19 48 at 4:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 19 48 to May 26 19 48 and that I last saw h...r alive on May 26 19 48

Immediate cause of death	DURATION
Cerebral Embolus	24 hrs.
Due to: Auricular Fibrillation	3 wks.
Due to: Caus[illegible] unknown.	
Other conditions: Arterio Sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: M. F. Klawans, MD
M. D. or other
Address: Annapolis, Md. Date signed 5/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. A. T. Allen
04589

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
3 O'Bryant Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 O'Bryant, Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Adam Brown

3. (b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Rebecca Brown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Feb. 15 1884
8. AGE: Years 64 Months 3 Days If less than one day ..... hrs. ..... min.
9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual occupation Pantry Help U.S.N.A.
11. Industry or business Annapolis
FATHER 12. Name Isaac Brown
13. Birthplace A. A.
MOTHER 14. Maiden name Eliza (unknown)
15. Birthplace A. A.
16. Informant Mrs. Ellen Smith
Address Annapolis
17. Buried (Burial, cremation, or removal. Which?) Date thereof May 17 1948 (month) (day) (year)
Cemetery or crematory Brewer Hill
Location Annapolis
18. Funeral director J. B. Johnson
Address Annapolis
19. May 17 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14 1948 at 7.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1- 1948 to 5-14 1948 and that I last saw him alive on 5-4 1948
Immediate cause of death Congestive heart failure — DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ..... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE A. T. Allen M.D. M. D. or other
Address 10 Carroll Date signed 5-17-48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04590

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs. 10 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 yrs. 10 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 208 W. Henrietta St.
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: AUSTIN BROWN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	divorced

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ---

FATHER
12. Name: George Brown
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Brown
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial, cremation, or removal. Which? Burial
Date thereof: 5-17-48 (month) (day) (year)
Cemetery or crematory: Mt Auburn Cem
Location: Balto City
18. Funeral director: Isaac L. Brown Son
Address: 108 W Monument St

19. (Date rec'd by registrar) May 14 19 48 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 19 48 at 5:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to May 11 19 48 and that I last saw him alive on May 11 19 48

Immediate cause of death	DURATION
General Paresis	
Known to us since	7/8/41
Due to	
Due to	
Other conditions: General Paresis	
known to us since	7/8/41

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? --- (City or town) --- (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 5/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, USE UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

STATE OF MARYLAND—CERTIFICATE OF DEATH

04591

94a

1. PLACE OF DEATH

County Anne Arundel County Registration Dist. No. 20

Village or City Brooklyn No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Sarah Brown If U. S. Veteran, specify WAR

(a) Residence: No. Brooklyn Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	colored	

5a. If married, widowad, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, dey, and year) Mar 1898?

7. AGE Years	Months	Days	If LESS than 1 dey, hrs. or min.
50 — ?	?	?	

OCCUPATION

8. Trada, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housekeeper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked et this occupation (month and year)

11. Total time (years) spant in this occupation

12. BIRTHPLACE (city or town) West River
(State or country) Md.

FATHER

13. NAME Phillip Brown

14. BIRTHPLACE (city or town) unknown
(Stata or country)

MOTHER

15. MAIDEN NAME Virginia Brown

16. BIRTHPLACE (city or town) unknown
(Stata or country)

17. INFORMANT Mrs Lean Galloway
(Address) Edgewater

18. BURIAL, CREMATION, OR REMOVAL
Place West River, Md. Date May 15, 1948

19. UNDERTAKER T. B. Johnson
(Address) Annapolis

20. FILED May 14, 1948 C. Gilbert Smith
Registrar.
Received May 21 48

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH
May (Month) 11 (Day), 1948 (Year).

22. I HEREBY CERTIFY, That I attended deceased from May 11, 1948, to May 11, 1948

I last saw her alive on May 11, 1948; deeth is said to hava occurred on tha date stated abova, at 6:30 P. m.

The **PRINCIPAL CAUSE OF DEATH** end related causes of Importance were as follows:

	Date of onset
Coronary thrombosis	
Other **Contributory Causes** of importance:	
Has had previous attacks	

Name of operation Date of

What test confirmed diagnosis? Was thera an autopsy?

23. If death wes due to extarnal causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur?
(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was diseese or injury In any way related to occupation of deceased?

If so, specify

(Signed) Emily H. Wilson M. D.

(Address) Lothian, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

for 30 b 04592

Reg. Dist. No. 15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 7 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr. 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1623 Madison Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ANTHONY CHAMBERLAIN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	widowed

6.(b) Name of husband or wife: ---
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1887

8. AGE: Years: 61 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: Amsted Chamberlain
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lucinda King
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/48 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: A. Halstead
18. Funeral director: 918 - Druid Hill Ave.
Address:

19. May 2 1948 (Date rec'd by registrar) C. W. Hepner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1948 at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 25 1947 to May 2 1948 and that I last saw him alive on May 2 1948

Immediate cause of death	DURATION
General Paresis known to us since	4/25/47
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of .....
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Carpenter M.D.
M. D. or other
Address: Crownsville, Md. Date signed 5/2/48

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161a

04593

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since birth.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: A. A. Co.

City or town: Harwood Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Chapman (TWIN #2)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	—

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 18, 1948

8. AGE: Years	Months	Days	If less than one day
			6 hrs. min.

9. Birthplace: Annapolis Md A. A Co. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Maurice Chapman

13. Birthplace: Lothian Md

MOTHER — 14. Maiden name: Rosetta Dorsey

15. Birthplace: Harwood, Md

16. Informant: Maurice Chapman

Address: Harwood, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 19, 1948 (month) (day) (year)

Cemetery or crematory: Union Chapel

Location: Harwood Md

18. Funeral director: J. B. Johnson

Address: Annapolis, Md.

19. May 19, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1948, at 7 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18, 1948 to May 18, 1948 and that I last saw h... alive on May 18, 1948

Immediate cause of death	DURATION
Atelectasis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Theodore H. Johnson M.D. M. D. or other

Address: 40 Northwest Street Annapolis, Md. Date signed 5/19/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93 e

04594

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs. 4 mos.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 yrs. 4 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: East New Market
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. 1
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: CHARLES H. CLARK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Agnes M. Clark
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 15, 1892

8. AGE: Years	Months	Days	If less than one day
56			____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: ---

FATHER
12. Name: Charles H. Clark
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ada Pinkett
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Md.

17. (Burial, cremation, or removal? Which?) Buried Cemetery or crematory: Cemetery Location: East New Market Date thereof: May 21 1948 (month) (day) (year)

18. Funeral director: E. B. Fillow Jr.
Address: East New Market

19. (Date rec'd by registrar) 5/19/ 48 E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 19 48 at 4:30 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41 to May 18 19 48 and that I last saw him alive on May 18 19 48

Immediate cause of death: Myocarditis — DURATION: 6 months
Due to: known to us
Due to:
Other conditions: Psychosis with Convulsive Disorders (Epilepsy) Epileptic Deteriorati on — since 1/16/35
(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op. --

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Morgenstern M.D.
M. D. or other
Address: Crownsville, Md. Date signed: 5/18/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15 9-45-15M

CERTIFICATE OF DEATH 93d

Registered No. [illegible]

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: A.A. Brooklyn Dist
(a) Baltimore City, Maryland
(b) Street address 203 E. Hillcrest Ave
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore City
(If outside city or town limits, write RURAL and give town)
(d) Street No. 203 E. Hillcrest Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Albert Ruckle Conner

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex M | 5. Color or race W | 6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of ~~husband or~~ wife Annie Conner

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 2nd 1869

8. AGE: Years 78 | Months 5 | Days 2 | If less than one day hr. min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual Occupation Retired

11. Industry or business Gas & Electric Co.

FATHER
12. Name Dr John Alexander Conner
13. Birthplace Md.

MOTHER
14. Maiden Name Mary Ellen Ruckle
15. Birthplace Balto. Md.

16 (a) Informant John A. Conner
(b) Address 415 W. 28th St.

17 (a) Burial (b) Date thereof 5/7/48
(Burial, ~~cremation, or removal~~) (month) (day) (year)
(c) Cemetery ~~or crematory~~ U.S. National
Location Balto. Md.

18 (a) Funeral director William Cook Inc
(b) Address 1247 St. Paul st

19 (a) MAY 6 - 1948 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

VS 151 5/6/48 G.W. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH [illegible] 5/4 1948, at 2 11 M

21. I certify that I took charge of the remains described above, held an Inspection thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary Disease

Due to Arteriosclerotic Cardiac Disease

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature [illegible] Fishback M.D.
Medical Examiner.
Date signed 5/5/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

92 b 04596

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
M H & .
How long in hospital or institution? May 22 1948

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Garrett
City or town: OAKLAND.
(If outside city or town limits, write RURAL and give nearest town)
Street No. /
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JOHN FREDERICK CROPP

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1888.

8. AGE: Years	Months	Days	If less than one day
60			hrs. min.

9. Birthplace: Oakland, Maryland. (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business
FATHER 12. Name: Not Known
13. Birthplace
MOTHER 14. Maiden name: Not Known
15. Birthplace
16. Informant: M H C and the patient. Address: Jessup Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof 5/27/48 (month) (day) (year)
Cemetery or crematory: Oakland,
Location: Jewett Co, Md
18. Funeral director: Wm Cole Inc.
Address: 1217 St. Paul St.
19. May 27 1948 (Date rec'd by registrar) Clara Haslett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 26 1948 at 12:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1948 to May 26 1948 and that I last saw h.. alive on May 26 1948

	DURATION
Immediate cause of death: Edema of the lungs.	
Due to: Mitral insufficiency with cardiac decompensation.	
Due to:	
Other conditions: Arteriosclerosis.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Clark M D (M. D. or other)
Address: Jessups, Md Date signed: 5/26/48

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

04597

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month 6 days
Hospital, Institution, or street address where death occurred:
Annapolis Emergency Hospital
How long in hospital or Institution? 1 month 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Annapolis Neck Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hattie Curry

3.(b) Social Security Number:

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Leonard Curry
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 1903
8. AGE: Years: 45 Months: Days: If less than one day: hrs. min.
9. Birthplace: A. A. Co. Md (Town, county, and state)
10. Usual occupation:
11. Industry or business:

FATHER
12. Name: Thomas E. Wallace
13. Birthplace: A. A. Co. Md

MOTHER
14. Maiden name: Griffin
15. Birthplace: A. A. Co. Md

16. Informant: Allen Wallace
Address: 1437 Myrtle Ave. Balto. Md
17. Burial, cremation, or removal. Which?: Burial Date thereof: May 5 48 (month) (day) (year)
Cemetery or crematory: Union Chapel Cemetery
Location: Mt. Rendrew, Md
18. Funeral director: E. A. Handley & Son
Address: Galesville, Md
19. May 3, 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 48 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19 ~~and that I last saw~~ alive on May 1, 19 48

	DURATION
Immediate cause of death: Shock	
Due to: Hemorrhage	
Fracture of pelvis	
Due to: Rupture of bladder	
Fracture of left fore-arm	
Other conditions: Fracture of Right Tibia & Fibula	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Mar. 26, 1948
Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): School St.
Means of injury: hit by automobile Injured at work? no

23. SIGNATURE: John M. Caffy M.D. Deputy Medical Examiner
Address: Annapolis, Md. Date signed: 5/1/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

04598

CERTIFICATE OF DEATH

Reg. Diat. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH: Anne Arundel

County

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: 51 Fleet Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 51 Fleet Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Dennis

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife Charles Dennis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 12, 1894

8. AGE: Years	Months	Days	If less than one day
53	8	10	..... hrs. ..... min.

9. Birthplace Annapolis, Maryland A.A.Co.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business None

FATHER 12. Name Fredrick Smith

13. Birthplace West River, Maryland

MOTHER 14. Maiden name Martha Gantt

15. Birthplace West River, Maryland

16. Informant Pearl Smith

Address 44 Northwest Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26, 1948 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location West Street Extended

18. Funeral director Mrs. Charles E. Hicks

Address 43-45 Northwest Street

19. May 26 19 48 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22nd 1948 at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28th 1948 to May 22nd 1948

and that I last saw h... alive on May 22nd 1948

Immediate cause of death	DURATION
respiratory failure	
Due to Carcinoma of Breast + metastasis	3 years
Due to + Breast + multiple metastases	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Edith Rollins, M.D. M. D. or other

Address 42 State Circle Annapolis Date signed 5-25-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160a

04593

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 164 Green St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wems William Duvall, Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 14th 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	3	..... hrs. ..... min.

9. Birthplace: Annapolis A. A. Co., Md.

(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER

12. Name: Wems W^m Duvall, Sr.

13. Birthplace: A. A. Co. Md.

MOTHER

14. Maiden name: Anna Claire Carter

15. Birthplace: Annapolis, Md.

16. Informant: Mrs. W. W. Duvall, Sr.

Address: 164 Green St. Annapolis, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5/18/48 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Annapolis Md

18. Funeral director: John M. Tayloe & Son

Address: Annapolis, Md.

19. May 18 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1948, at 6a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14th 1948 to May 17 1948 and that I last saw him alive on May 17 1948

Immediate cause of death	DURATION
Intracranial Hemorrhage	2 days
Edema of New Born	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo. C. Boyd M. D. or other

Address: Annapolis Md Date signed 5-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

185

04600

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years 9 months

Hospital, institution, or street address where death occurred: USNA, Annapolis, Md.

How long in hospital or institution? 20 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Wyoming County: Carbon

City or town: Rawlings (If outside city or town limits, write RURAL and give nearest town)

Street No.: 221 East Front (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: ELIOPULOS, George James

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 15 April 1927

8. AGE: Years	Months	Days	If less than one day
21	-	25	... hrs. ... min.

9. Birthplace: Rawlings, Wyoming (Town, county, and state)

10. Usual occupation: Student

11. Industry or business:

FATHER — 12. Name: James Eliopulos

13. Birthplace: Greece

MOTHER — 14. Maiden name: Unkown

15. Birthplace: Greece

16. Informant: Records Office

Address: U.S.NAVAL ACADEMY, Annapolis, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5-12-48 (month) (day) (year)

Cemetery or crematory:

Location: Rawlings, Wyoming

18. Funeral director: Ben L. Hopping and Son

Address: 170-172 West St. Annapolis, Md.

19. May 12 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 May 1948, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 May 1948, to 10 May 1948 and that I last saw him alive on 10 May 1948

Immediate cause of death	DURATION
Wound, Punctured, Left Supraclavicular Region	20 min.
Due to: A thrown javelin causing hemorrhage traumatic into right pleural	
Due to: cavity and posterior mediastinum	15 min.
Other conditions: (Include pregnancy within 3 months of death)	

Major findings of operations: ... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 10 May 1948

Where did injury occur? Annapolis, Anne Arundel, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where): U.S.Naval Academy, Thompson Stadium.

Means of injury: Organized Athletics Injured at work? Yes

23. SIGNATURE: [signature] M.D. Lt. Comdr. (MC) USN

Address: ... Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Evidence for change of age shown on:

FILM No. G 115 MAY 18 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04601

Reg. Diat. No. 29

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo. 27 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 mo. 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: --
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1354 Cleveland St.
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: ALICE FIELD

3.(b) Social Security Number:

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 18, 1901

8. AGE: Years: 47 46 | Months | Days | If less than one day: hrs. min.

9. Birthplace: Kentucky
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: --

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: hospital records
Address: Crownsville, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/10/48 (month) (day) (year)
Cemetery or crematory: Hospitals
Location: Crownsville Md

18. Funeral director: Asylum Hospital
Address: Crownsville, Md

19. 5-10 1948 E7 Jones Coral Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1948 at 11:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9 1948 to May 6 1948 and that I last saw her alive on May 6 1948

	DURATION
Immediate cause of death: General Paresis	
known to us since	3/9/48
Due to:	
Due to:	
Other conditions: General Paresis	
known to us since	3/9/48

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op. ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -- Date of
Where did injury occur? -- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of Injury: Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other
Address: Crownsville, Md. Date signed: 5/6/48

MARGIN RESERVED FOR BINDING

Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

PLEASE WRITE PLAINLY, WITH UNFADING INK

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04602

97

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years, 1 month, 13 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 6 years, 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 608 Dolphin
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: MARGARET FISHER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1882

8. AGE: Years	Months	Days	If less than one day
66	?	?	hrs. min.

9. Birthplace: ?
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial, cremation, or removal. Which? burial
Date thereof: 6/31/1948 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto City

18. Funeral director: Wm. Lane T. Hensley
Address: 5438 W. Biddle

19. 6/1, 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28th 1948 at 7:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1942 to May 28th 1948 and that I last saw her alive on May 28th 1948

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to: Known to us since 4/15/42	
Due to:	
Other conditions: Senile Psychosis	Known to us since 4/15/42

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ———— Date of:

Where did injury occur? ———— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ————

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D.
M. D. or other

Address: Crownsville, Maryland Date signed: 5/28/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

31

932d 04603

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: A. A. County
City or town: Gibson Island
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Broadmoor Rd.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 102 St. Albans Way
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Carrie N. Gift

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	W	Widow

6.(b) Name of husband or wife: Foster U. Gift
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jun. 17, 1872

8. AGE: Years	Months	Days	If less than one day
75	10	10	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: John G. M. Swengle
13. Birthplace: Pa.

MOTHER
14. Maiden name: Dunkle
15. Birthplace: Pa.

16. Informant: Mrs. Geo. F. Lang
Address: 102 St. Albans Way

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/29/48 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Pikesville, Md

18. Funeral director: Wm. J. Tickner & Sons
Address: Balto, Md.

19. May 28, 1948 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1948 at 7 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25 1946 to May 27 1948 and that I last saw h[illegible] alive on May 27 1948

Immediate cause of death	DURATION
Myocardial Insufficiency	2 yrs
Due to Arteriosclerosis	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John W. Carnoon M. D. or other
Address: 1109 St. Paul St. Date signed: 5-29-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

04604

1. PLACE OF DEATH
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs. 3 mos.
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 4 yrs. 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: --
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1451 Parrish St.
(If rural, give LOCATION)
2.(a) If veteran, name war: --

3.(a) FULL NAME: J. D. GILLIAM

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: Hazel Gilliam
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 1, 1916

8. AGE: Years	Months	Days	If less than one day
31	8	23	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Elevator operator
11. Industry or business: ---

FATHER
12. Name: Morris Gilliam
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Tecoria Wilson
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/48 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Balto County
18. Funeral director: Wm A Jackson
Address: 916 Penna Ave

19. May 27 1948 (Date rec'd by registrar) A. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1948 at 12:05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1944 to May 22 1948
and that I last saw h in alive on May 24 1948

Immediate cause of death	General Paresis	DURATION 2/8/44
	Known to us since	
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op. --
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? --- (City or town) --- (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury: --- Injured at work?

23. SIGNATURE: Jack Marquardt M. D.
Crownsville, Md. M. D. or C. 5/22/48
Address: Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Baltimore
(If outside city limits, write RURAL and give nearest town)
How long in above place of death:
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Glen Burnie
(If outside city limits, write RURAL and give nearest town)
Street No. 322 1st Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Pauline Georgette Grundstrum — **3.(b) Social Security Number**

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Edward Grundstrum
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Jan 12 1892
8. AGE: Years: 56 Months: 4 Days: 2 If less than one day: ..... hrs. ..... min.
9. Birthplace: Baltimore Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. FATHER — Name: Wilhom Hickman
13. FATHER — Birthplace: Crisfield Md
14. MOTHER — Maiden name: Charlotte Rhoebus
15. MOTHER — Birthplace: Crisfield Md
16. Informant: Mrs Cathy James
Address: Glen Burnie Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/48 (month) (day) (year)
Cemetery or crematory: Johns Hopkins
Location: Baltimore Md
18. Funeral director: Wilhom Funeral Home
Address: 1219 E Cold St
19. 5/17/48 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1948 at 4:30 P M
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 1 1948 to May 14 1948
and that I last saw him alive on May 14 1948
Immediate cause of death: Cerebral Hemorrhage — DURATION
Due to:
Due to:
Other conditions: Malignant Hypertension
(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Glen Burnie Md May 14 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a 046064 42

Reg. Dist. No.

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: LANDOWNE, MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: ANNE ARUNDEL
City or town: LANSDOWNE, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2711 HAMMONDS FERRY RD
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: MARGARET McLEAN GUY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	SINGLE

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEB. 29, 1864

8. AGE: Years	Months	Days	If less than one day
84	2	15	hrs. min.

9. Birthplace: BALTO, MD.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: WM. GUY
13. Birthplace: BALTIMORE, MD.

MOTHER
14. Maiden name: SARAH A. GUY
15. Birthplace: BALTO, MD.

16. Informant: WM. A. HOOVER (LANDOWNE, MD)
Address: 2711 HAMMONDS FERRY RD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5/14/48 (month) (day) (year)
Cemetery or crematory: LONDON PARK
Location: BALTO., MD.

18. Funeral director: WM. J. TICHNER & SONS
Address: BALTO, MD.

19. May 11 19 48 (Date rec'd by Registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/11 19 48 at 9 15 A.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 2/1 19 48, to 5/11 19 48 and that I last saw h[illegible] alive on 5/10 19 48

Immediate cause of death	DURATION
Coronary Thrombosis	1 month
Due to Hypertension	
Due to Arterial Sclerosis	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. Cahn M. D. or other
Address: 2145 W. Balto St. Date signed: 5/12-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

YS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166

04697

CERTIFICATE OF DEATH

Reg. Diat. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 28 Gotts Court
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)
Street No.: 28 Gotts Court (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Standola Hamilton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 20, 1920

8. AGE: Years	Months	Days	If less than one day
28	3	23	hrs. min.

9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: James Young
13. Birthplace: A.A.Co.

MOTHER
14. Maiden name: Eliza Elizabeth Hamilton
15. Birthplace: A.A.Co.

16. Informant: Elizabeth Washington
Address: 28 Gotts Court, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25, 1948 (month) (day) (year)
Cemetery or crematory: Asbury
Location: Annapolis, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis, Md. R.F.D. [illegible]

19. May 25 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1948, at 7 15 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Postmortem Examination 19 ~~[illegible]~~ May 22 1948

Immediate cause of death	DURATION
Bullet wound in	
Due to: neck	Sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 5-22-48
Where did injury occur? Annapolis (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): 28 Gotts Court
Means of injury: 38 Cal. bullet Injured at work? no

23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 5-24-48

Evidence for change of birth date shown on: [illegible] MAY 27 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a 046118 20

File No. G 11 Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Lothian - Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Lothian - Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Kate Miriam Mitchelmore Hereford

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Richard Levi Hereford

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 12 - 1858

8. AGE: Years	Months	Days	If less than one day
89	4	11	____ hrs. ____ min.

9. Birthplace: Falmouth, Cornwall, England.

(Town, county, and state)

10. Usual occupation: none.

11. Industry or business

FATHER

12. Name: Thomas Mitchelmore

13. Birthplace: England.

MOTHER

14. Maiden name: Elizabeth Butsons.

15. Birthplace: England.

16. Informant: Katherine Clagett.

Address: Harwood Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 1948 (month) (day) (year)

Cemetery or crematory: Trinity Episcopal

Location: Marlboro Pk. Geo. Co. Md.

18. Funeral director: Ritchie Bros.

Address: Main St. Upper Marlboro Md.

19. 5/21/48 (Date rec'd by registrar) W. M. Clayton Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1948, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to May 20 1948

and that I last saw h.e.r. alive on May 19 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Emil H. Nilsen, M.D. M. D. or other

Address: Lothian. Date signed: 5/21/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04609

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs. 5 mos.
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 5 yrs. 5 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 563 Laurens St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: JOHN E. HOLMES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	SINGLE

6.(b) Name of husband or wife: ---
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 10, 1919

8. AGE:

Years	Months	Days	If less than one day
28	10	3	____ hrs. ____ min.

9. Birthplace: New Jersey
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ---

FATHER
12. Name: Henry Clay Holmes
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Nancy E. Brown
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1948 (month) (day) (year)
Cemetery or crematory: Gate of Heaven
Location: Mt. Rafal N. J.
18. Funeral director: Arthur A. Harden
Address: 824 Kingsley Ave. Glenolden, Pa.

19. May 14 1948 (Date rec'd by registrar) A. F. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1948 at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1942 to May 13 1948 and that I last saw him alive on May 13 1948

Immediate cause of death: Tuberculosis of the Lungs. Known to us since — DURATION: 4/30/48

Due to:

Due to:

Other conditions: Schizophrenia - Paranoid Type. Known to us since 12/4/42
(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: --- Injured at work?

23. SIGNATURE: Jacob Marquette M.D.
M. D. or other
Address: Crownsville, Md. Date signed 5/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Anderson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

147d

04610

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Defence Hwway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ELEANORA G. HOMBERG

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Robert Homberg
6.(c) If alive, give age: 35 years
7. Birth date of deceased (mo., day, yr.): 1-12-1917

8. AGE: Years	Months	Days	If less than one day
31	5	15	...hrs. ...min.

9. Birthplace: Anne Arundel Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business

FATHER
12. Name: Joseph C. Grierson
13. Birthplace: Calvert Co. Maryland

MOTHER
14. Maiden name: Annie Whitting
15. Birthplace: Anne Arundel, Maryland

16. Informant: Mr. Robert Homberg
Address: Defence Highway, r Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-31-48 (month) (day) (year)
Cemetery or crematory: Edward's Chapel
Location: Parole, A.A. Co. Maryland

18. Funeral director: B.L. Hopping and Son
Address: 170-172 West St. Annapolis, Maryland

19. May 30, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1948 at 5:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24, 1948 to May 27 1948 and that I last saw h... alive on May 24, 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage (left side)	Immediate
Due to: Embolism.	
Due to:	
Other conditions: Secondary Anemia (Postpartum) - Live female delivered at home - 5/11/48 - By midwife	

(Include pregnancy within 3 months of death)
Major findings of operations: Date of op...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gilbert R. Anderson M.D. M. D. or other
Address: Annapolis, Md. Date signed: 5/27/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1948-5-27
31-5-15
1917-8-12

04611

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, be sure it is correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County A. A.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yr.

Hospital, institution, or street address where death occurred:

Vista Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

Street No. Vista Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Elizabeth Hoy

3.(b) Social Security Number NONE,

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~F~~ F	White	Single

6.(b) Name of husband or wife None.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) February 25, 1874

8. AGE:

Years	Months	Days	If less than one day
74	2	18	..... hrs. ..... min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation None.

11. Industry or business

FATHER

12. Name John T. Hoy

13. Birthplace Ireland.

MOTHER

14. Maiden name Harriet E. Stevens (EISRODE)

15. Birthplace Rockland Md.

16. Informant EDWARD HOY

Address Ferndale, Md

17. BURIAL (Burial, cremation, or removal, Which?) Date thereof May 15, 1948 (month) (day) (year)

Cemetery or crematory LOUDON PARK

Location Baltimore, Md

18. Funeral director Thomas W Singleton

Address Glen Burnie, Md

19. 5/15 19 ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 48 at 10:40 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 19 48, to May 13 19 48 and that I last saw h. alive on May 13 19 48

Immediate cause of death	DURATION
Cerebral Hemorrhage	Feb-13-48
Due to Arteriosclerosis	5 yr.
Due to Hypertension	5 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Ball Jr M.D.
M. D. or other

Address Linthicum Md. Date signed 5-13-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

1316 04612 23

Reg. Diat. No. .....

1. PLACE OF DEATH:
County Anne Arundel
City or town Marley Park - P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years.
Hospital, Institution, or street address where death occurred: Queen Anne Road.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... County .....
City or town .....
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Elizabeth M. Ireland.

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife John A. Ireland.
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) January 13 1901

8. AGE:

Years	Months	Days	If less than one day
47	3	24	..... hrs. ..... min.

9. Birthplace Harwood Baltimore Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Walter McKew Hall
13. Birthplace Baltimore, Md.

MOTHER
14. Maiden name Sophia Peiffert.
15. Birthplace Baltimore, Md.

16. Informant Mr. John A. Ireland (Husband)
Address Marley Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10-1948 (month) (day) (year)
Cemetery or crematory Glen Haven
Location A A Co Md
18. Funeral director Pratt & Stokes B. M. Walter
Address Pratt & Stokes D.C.

19. May 7 1948 A. W. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1948 at 6:31 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1948, to May 6 1948 and that I last saw h.. alive on 5/6/48 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days.
Due to Mitral Insufficiency	?
Due to Chronic nephritis	?
Other conditions Obesity.	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Gustave H. Parker M.D.
5 Fontaine St. E. M. D. or other
Address Glen Burnie Md. Date signed 5/7/48

MARGIN RESERVED FOR BINDING

I PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04613

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 27 Obriens St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Naomi Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14, 1888

8. AGE: Years	Months	Days	If less than one day
60	1	19	..... hrs. ..... min.

9. Birthplace Annapolis-AA- Md. (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER — 12. Name

13. Birthplace Unknown

MOTHER — 14. Maiden name

15. Birthplace Unknown

16. Informant Elizabeth Johnson

Address 27 Obriens St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 5 48 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location West St. Annapolis, Md.

18. Funeral director William Rose, II

Address 108 Washington St.

19. May 5, 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1948, at 4 05 A M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmorten Examination 19..... ~~and that I last saw him alive on~~ May 2 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden
Due to Arterial Hypertension	unknown
Due to Arterio-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE John M. Cuffy M.D. Deputy Medical Examiner M. D. or other

Address Annapolis, Md. Date signed 5/3/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04614

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Station Hospital

How long in hospital or institution? two (2) hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 17 Cedarwood Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war: Spanish Am., World #1 & #2

3.(a) FULL NAME: OTHO W. JOHNSON (Otho Woodson Johnson)

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Anna Orchard Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 19, 1877

8. AGE: Years	Months	Days	If less than one day
70	6	23	..... hrs. ..... min.

9. Birthplace: Marionville, Va.
(Town, county, and state)

10. Usual occupation: U. S. A. Retired Major

11. Industry or business

FATHER
12. Name: James E. Johnson
13. Birthplace: Va.

MOTHER
14. Maiden name: Sarah Benson
15. Birthplace: Va.

16. Informant: Mrs. Anna Johnson wife
Address: 17 Cedarwood Rd. Catonsville 28

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/48 (month) (day) (year)
Cemetery or crematory: Balto. National Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 14 May 19 48 (Date rec'd by registrar)
James N. Goerger
JAMES N. GOERGER, Capt., MSC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 MAY 19 48 at 1145 hrs

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw him alive on 12 May 19 48

Immediate cause of death	DURATION
Acute coronary occlusion with posterior wall myocardial infarction	2½ Hrs
Due to: generalized arteriosclerosis obliterans.	7½ YRS.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: No autopsy performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. G. Magida
M. G. MAGIDA, 1st Lt., M.C. M.D. or other

Address: Ft Geo G Meade, Md. Date signed: 14 May 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Sanders Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Sanders Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Sanders Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sanders Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Benjamin J. Kicklighter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

8.(b) Name of husband or wife: Juanita Zorens

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 25 1896

8. AGE: Years	Months	Days	If less than one day
51	6	9	hrs. min.

9. Birthplace: Maycross Ga. (Town, county, and state)

10. Usual occupation: Retired Steel Worker

11. Industry or business: Proprietor - Tavern

FATHER 12. Name: McLennon Kicklighter

13. Birthplace: "

MOTHER 14. Maiden name: "

15. Birthplace: "

16. Informant: Co. Police Dept.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/8/48 (month) (day) (year)

Cemetery or crematory: Oakhill

Location: Brooklyn Md.

18. Funeral director: Wilson Colored

Address: 1217 E. Coul St.

19. May 7 1948 (Date rec'd by registrar) A. W. Hebron Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1948, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/29 1947, to 5/4 1948

and that I last saw him alive on May 3 1948

Immediate cause of death	DURATION
Uremia Nephritis	
Due to: Arteriosclerosis	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D. M. D. or other

Address: Riviera Beach Date signed: 5/4/48

Dr Smith's
Bill
Sunset 290 or 49R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 f

04616

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos.

Hospital, Institution, or street address where death occurred: R.F.D. #2

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mill Creek R.F.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Katherine Helen LeCompte

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: Lt. Stuart B. LeCompte

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): February 8, 1886

8. AGE:

Years	Months	Days	If less than one day
62	2	27	...hrs. ...min.

9. Birthplace: Buxton, Ontario, Canada

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Andrew Young

FATHER 13. Birthplace: Scotland

MOTHER 14. Maiden name: Elizabeth Cooper

MOTHER 15. Birthplace: Scotland

16. Informant: Stuart Burnette LeCompte

Address: R.D. 2, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7, 1948 (month) (day) (year)

Cemetery or crematory: Laudon Park

Location: Frederick Road.

18. Funeral director: Harry E. Darby

Address: 1908 Eutaw Place

19. 5/7 1948 (Date rec'd by registrar) A W Kedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1948 at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 24 1948 to May 5 1948 and that I last saw her alive on May 1 1948.

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Carcinoma of liver	1 year
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Peyton Ritchie, M.D.

M. D. or other

Address: Annapolis, Md. Date signed: May 5, 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95 c

04617

CERTIFICATE OF DEATH

Reg. Diat. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Hanover

(If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos.

Hospital, Institution, or street address where death occurred:

Home - Ridge Rd.

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Hanover

(If outside city of town limits, write RURAL and give nearest town)

Street No.: Ridge Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war: W

3.(a) FULL NAME: John G. Leibold

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Ethel Leibold

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Mar 9th 1884

8. AGE: Years	Months	Days	If less than one day
64	2	22	..... hrs. ..... min.

9. Birthplace: Balto. Md. (Town, county, and state)

10. Usual occupation: Printer

11. Industry or business: Leibold Printing Co.

FATHER 12. Name: John George Leibold

13. Birthplace: Germany

MOTHER 14. Maiden name: Louise (Unknown)

15. Birthplace: Germany

16. Informant: Ethel Leibold

Address: Ridge Rd - Elkridge Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/3/48 (month) (day) (year)

Cemetery or crematory: Lorraine

Location: Balto. Co. Md.

18. Funeral director: William Cook Inc.

Address: 127 St. Paul St.

19. 6/1 19 48 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1948, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~

..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Acute dilatation of heart	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Leyton Ritchings M.D.

M.D. or other

Address: Annapolis, Md. Date signed: May 31, 1948

Luck, Baby Boy

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

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04618

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: U.S. Naval Hospital, Annapolis, Md.
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 8 Laurel Street, Homoja Village
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Dale LUCK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 27, 1948

8. AGE:

Years	Months	Days	If less than one day
0	0	3	hrs. min.

9. Birthplace: Annapolis, Ann Arundel CO., Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Edward B. LUCK
13. Birthplace: Berkeley, California

MOTHER
14. Maiden name: Lucille Beatrice Bonani
15. Birthplace: Quincy, Mass.

16. Informant: Edward B Luck
Address: 8 Laurel St Homoja Village

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 1948 (month) (day) (year)
Cemetery or crematory: Naval Academy Cemetary
Location: Annapolis, Maryland

18. Funeral director: B. F. Hopping Funeral Home
Address: 192 West Street, Annapolis, Md.

19. June 1, 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1948, at 4.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1948 to May 30 1948 and that I last saw h.. alive on May 29 1948

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D., or other
Address: U.S.N. Hosp. Date signed: 5/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

04622

Reg. Dist. No. 2-2

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Barberville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Barberville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Herbert Merson Sr

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Pauline Merson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 17, 1900

8. AGE:

Years	Months	Days	If less than one day
48	3	22	hrs. min.

9. Birthplace: Burtonsville, Montgomery, Md.

(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Construction

FATHER

12. Name: Edgar Merson

13. Birthplace: Md

MOTHER

14. Maiden name: Stella ?

15. Birthplace: —

16. Informant: Mrs Pauline Merson

Address: Laurel, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10, 1948 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Burtonsville, Md.

18. Funeral director: De Witt Donaldson

Address: Laurel, Maryland

19. May 10 1948 (Date rec'd by registrar) Clara Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1948 at 6:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 1st 1943 to May 7 1948

and that I last saw h[illegible] alive on May 7 1948

Immediate cause of death	DURATION
Chronic Myocarditis	1 1/2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert S McCreary M. D. or other

Address 402 Main St Laurel Md. Date signed 5/9/48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

830 04613

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: R.F.D. Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Skidmore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Matthews

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Pheaba Matthews
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1871

8. AGE: Years	Months	Days	If less than one day
77	2	15	hrs. min.

9. Birthplace: A.A.CO.MD. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Matthews
13. Birthplace: A.A.CO.MD.

MOTHER
14. Maiden name: Sarah Richardson
15. Birthplace: A.A.CO.MD.

16. Informant: Pheaba Matthews
Address: R.F.D.2 Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30 1948 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: Skidmore, Md.

18. Funeral director: J.P. Johnson
Address: Annapolis, Md. P.O. Box 462

19. May 29 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1948 at 12 40 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 7 1948 to 5-26 1948
and that I last saw him alive on 5-26-48 1948

Immediate cause of death	DURATION
Cerebro-vascular accident.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. T. Allen Jr M.D.
M. D. or other
Address: 10 Carroll Date signed: 5-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS AT5 9-45-15M

:::::::::: Name of deceased: Form VS 26(44) filmed G 116 6-8-48 LL

MARYLAND STATE DEPARTMENT OF HEALTH

*LETTER FROM MRS. MC CULLY
FILMED G116 6-10-48 L

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04620

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: near Davidsonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? sudden death
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3871 Alabama Ave. S.E.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Hamilton H. McCully

3.(b) Social Security Number 578-01-3647

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Sarah E. Giddens McCully
*SARAH ELIZABETH GIDDENS McCULLY
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): Oct. 26, 1896

8. AGE:	Years	Months	Days	If less than one day
(51)	51	6	20	hrs. min.

9. Birthplace: Idaville, Indiana
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: Building Supt
FATHER 12. Name: Frank E. McCully
13. Birthplace: Indiana
MOTHER * ADDA 14. Maiden name: Addie Meyers
15. Birthplace: Indiana
16. Informant: Mrs. Sarah E. G. McCully
Address: 3871 Alabama Ave. S.E. Wash D.C.
17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/16/48 (month) (day) (year)
Cemetery or crematory: Murray Funeral Home
Location: Washington D.C.
18. Funeral director: T. B. Hardesty & Son
Address: Galesville Md.
19. May 16 1948 (Date rec'd by registrar) Edward Coleman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1948 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post Mortem Examination 19.....
~~and that I last saw him alive on~~ May 16, 1948

	DURATION
Immediate cause of death	
Due to: Coronary occlusion	Sudden
Due to: Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Cathey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 5/16/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

III

16 - 46 - 147
X - X2 - 27
10 - 26 - 1876
6 - 220 - 31

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04621

94a

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: N. Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: U.S.N. Experiment Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1116 Monroe St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME WINFRED LEWIS McKEYES

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Lula Mae McKeyes

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 6th 1902

8. AGE:

Years	Months	Days	If less than one day
45	6	18	hrs. min.

9. Birthplace: Iowa (Town, county, and state)

10. Usual occupation: Leading man (Diesel Eng.

11. Industry or business: N. S. N. Experimental Station

FATHER

12. Name: Andrew McKeyes

13. Birthplace: Penn.

MOTHER

14. Maiden name: Anna Schwartz

15. Birthplace: Kentucky

16. Informant: Mrs. W. L. McKeyes

Address: Eastport, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5/27/48 (month) (day) (year)

~~Cemetery or crematory~~ Des Moines,

Location: Iowa

18. Funeral director: John M. Taylor & Son

Address: Annapolis

19. May 26 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1948, at 10:15 A.M.

21. I CERTIFY that death occurred on the date above stated: the undersigned

Post mortem Examination

attended the deceased from May 24 1948

Immediate cause of death	DURATION
Due to: Coronary occlusion	Sudden
Due to: Coronary sclerosis	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Cuffy M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis Md. Date signed 5/25/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

151a

04623

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County Anne Arundel
City or town Arnold Annex - P.O. Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1941
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State D. C. County
City or town Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2914 Vista St. N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ella Theresa Mertz.

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	married

6.(b) Name of husband Peter Antonio Mertz
6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Aug. 14 - 1872.

8. AGE:

Years	Months	Days	If less than one day
75	9	10	hrs. min.

9. Birthplace Louis County - West Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name William Reedy
13. Birthplace Ireland.

MOTHER
14. Maiden name Elizabeth Campbell
15. Birthplace Ireland. Md.

16. Informant Mrs. P. A. Mertz, (Husband)
Address Arnold Annex, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/26/48 (month) (day) (year)

Cemetery or crematory
Location Washington, D. C.

18. Funeral director Tubaty, Bonlore
Address 641 - H St. N.W.

19. 5/24/48 (Date rec'd by registrar) Ella Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1948, at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 1947 to May 24 1948 and that I last saw h.. alive on 5/24/48. 1948

Immediate cause of death	DURATION
Mitral Insufficiency	7 months.
Due to Chronic Interstitial nephritis	7 mth.
Due to Anemia.	
Other conditions Senelety	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave H. Faubert M.D. M. D. or other
Address Glen Burnie, Md. Date signed 5/24/48.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B1a 04624

Reg. Dist. No. 25

1. PLACE OF DEATH:

County Anne Arundel

City or town Garland - P.O. Ferndale. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 years

Hospital, Institution, or street address where death occurred: 110 - Linden Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State ... County ...

City or town ... (If outside city or town limits, write RURAL and give nearest town)

Street No. Same. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George John Moller.

3.(b) Social Security Number 116-05-8066 B.

4. Sex M.

5. Color or race White

6.(a) Single, married, widowed, or divorced Married.

6.(b) Name of ~~husband~~ or wife Marie Panzenpeck

6.(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) 11/1/1872

8. AGE: Years 75 Months 6 Days 10 If less than one day ... hrs. ... min.

9. Birthplace Germany, Europe. (Town, county, and state)

10. Usual occupation Iron Instructor.

11. Industry or business

FATHER 12. Name Hanibal Moller

13. Birthplace Germany.

MOTHER 14. Maiden name ? Elizabeth Fröhder

15. Birthplace Hessen, Darmstadt.

16. Informant Mr. G. J. Moller

Address Linden Ave - P.O. Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14-48 (month) (day) (year)

Cemetery or crematory Glen Haven Cemetery.

Location Glenburnie Md.

18. Funeral director Milton Schilling

Address 3914 Hanover St. -25-

19. May 11 1948 (Date rec'd by registrar) Ida M. Whitman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1948, at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1947 to May 10 1948

and that I last saw him alive on 5/10/48. 19...

	DURATION
Immediate cause of death Mitral Insufficiency	8 mos.
Due to Interstitial nephritis.	8 "
Due to General arteriosclerosis.	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Gustave H Pauker M.D. M. D. or other

Address 5 First Ave. E. Glen Burnie Md. Date signed 5/11/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04625

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Near Severn, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn, Rural.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3.(a) FULL NAME: ANDREW MORRISON

3.(b) Social Security Number: UNKNOWN

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Widower

6.(b) Name of husband or wife: Anne Morrison
6.(c) If alive, give age: deceased years

7. Birth date of deceased (mo., day, yr.): September 23, 1892

8. AGE:

Years	Months	Days	If less than one day
55	7	10	..... hrs. ..... min.

9. Birthplace: Laurel. Prince George Co. Md.
(Town, county, and state)

10. Usual occupation: Farm hand

11. Industry or business: Warfield's Farm, Severn, Md.

FATHER
12. Name: William F. Morrison
13. Birthplace: Laurel, Prince Goerge Co., Md.

MOTHER
14. Maiden name: Gertrude Stanton
15. Birthplace: Mechanicsville, Md.

16. Informant: Gilbert Smith
Address: Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6, 1948 (month) (day) (year)
Cemetery or crematory: Baltimore National
Location: Baltimore, Md.

18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.

19. 5/6 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1948 at 11:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Coronary occlusion — DURATION: Sudden

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Everett J. Beachley, M.D.
Acting Deputy Med. Examiner
M. D. or other
Address: Glen Burnie, Md. Date signed: 5/4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr. M. L. Klaumm

93d

04626

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: A. A.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Shadmore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Log Inn Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Murray

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	Widow

6.(b) Name of husband or wife: Alberta Murray

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 10 1870

8. AGE: Years 77 | Months 9 | Days .0 | If less than one day: hrs. min.

9. Birthplace: Shadmore (town, county, and state)

10. Usual occupation: Labor

11. Industry or business

FATHER 12. Name: race A. Murray

13. Birthplace

MOTHER 14. Maiden name: Mary Wiltyle

15. Birthplace

16. Informant: Caleb Murray

Address: R.F.D. 2 Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1948 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: Md.

18. Funeral director: J. B. Johnson

Address: Annapolis

19. May 12 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1948 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 1948 to May 13 1948 and that I last saw h[illegible] alive on May 13 1948

Immediate cause of death	DURATION
Chr. Myocarditis	
Due to (Arteriosclerosis C. V. Disease)	
Due to	
Other conditions: Sinusitis (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. J. Klaumm M.D. M. D. or other

Address: Annapolis, Md. Date signed: 5/14/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

120a

04627

CERTIFICATE OF DEATH

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Ann Arundel

City or town Furnace Branch
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Ann Arundel

City or town Furnace Branch
(If outside city or town limits, write RURAL and give nearest town)

Street No. Furnace Branch Road
(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME ELEANORA MUSE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife Ruehen

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) October 22nd 1866

8. AGE: Years	Months	Days	If less than one day
81	6	20	..... hrs. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John Coleman

13. Birthplace Md

MOTHER 14. Maiden name Georgia Wilkes

15. Birthplace Md

16. Informant Estella Dorsey

Address Furnace Branch Rd, Furnace Br Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/48 (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Balto. Md

18. Funeral director Charles G. Cooper

Address 510-12 N. Carrollton Ave

19. 5th (Date rec'd by registrar) 1948 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12th 1948 at 4:01 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1948 to May 12 1948 and that I last saw ~~her~~ alive on May 11 1948

Immediate cause of death	DURATION
Heart Failure	
Due to Colitis	
Due to Rectal Prolapse	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Elkridge Md Date signed 5/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 · 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

04628

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Greenhaven (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Balto Anne Arundel

City or town: Greenhaven (If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Christian F. Nagel Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Nagel

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 10th 1888

8. AGE: Years	Months	Days	If less than one day
60			..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Grocery Store

11. Industry or business: Owner

FATHER 12. Name: Christian Nagel Sr

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Olga Young

MOTHER 15. Birthplace: Germany

16. Informant: Mrs Margaret Nagel

Address: Greenhaven Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18th 1948 (month) (day) (year)

Cemetery or crematory: Lorraine Park

Location: Windsor Mill Road

18. Funeral director: Leo G. Crook

Address: 1701-03 N. Patterson Park Ave

19. 5/19 19 48 A. W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to May 14 1948 and that I last saw h... alive on May 14 1948

Immediate cause of death	DURATION
Coronary occlusion	3 mo.
Due to: Angina Pectoris	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: 3307 Edmondson Ave Date signed: May 17 48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28 — 04629

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 3 mos.

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 yrs. 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Williamsburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ---
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: LINWOOD NEWCOMB

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): March 20, 1917

8. AGE: Years: 31 | Months: | Days: | If less than one day: ...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER — 12. Name: Tom Newcomb (deceased)

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mandy Jones (deceased)

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital records

Address: Crownsville, Md.

17. (Burial, cremation, or removal. Which?) burial — Date thereof 6-11-48 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt. Hospital

Address: Crownsville Md

19. 6/11/48 (Date rec'd by registrar) — E. F. Joyce Loral, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 19 48 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 19 43 to May 26 19 48 and that I last saw him alive on May 26 19 48

Immediate cause of death: Pulmonary Tuberculosis — DURATION: 10/16/47

known to us since

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: ---

Date of op. ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury: Injured at work?

23. SIGNATURE: Jacob Mercantz M.D.
M. D. or Coroner

Address: Crownsville, Md. Date signed: 5/26/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

84a

04630

20

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West River Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: West River Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: L

3.(a) FULL NAME: William Phipps

3.(b) Social Security Number: L

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 30 1947
8. AGE: Years: 1 Months: 4 Days: If less than one day: hrs. min.
9. Birthplace: West River Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Spencer A. Phipps
13. Birthplace: West River Md.
MOTHER 14. Maiden name: Ina Lorraine Collinson
15. Birthplace: Neale
16. Informant: Spencer A. Phipps
Address: West River Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1948 (month) (day) (year)
Cemetery or crematory: Our Lady of Lourdes Catholic
Location: West River Md
18. Funeral director: F. G. Hardesty & Son
Address: Galesville Md
19. 5/31/48 (Date rec'd by registrar) M. Clarke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1948 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 30 1947 to May 30 1948 and that I last saw him alive on May 20 1948

Immediate cause of death: Congenital Disease — Congenital Heart Disease — DURATION

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D.
M. D. or other
Address: Lothian, Md. Date signed 5/30/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 B 04631

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 45 yr.

Hospital, institution, or street address where death occurred:

Odenton Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Severn

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Odenton R-C.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Catherine McCracken Redmiles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Lewis J. J. Redmiles

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 16 1877

8. AGE: Years: 73 | Months: 10 | Days: 12 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Felix McCracken

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Ann Carrigan

15. Birthplace: Ireland

16. Informant: Mr. Thomas F. Redmiles

Address: Telegraph Rd, Severn Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: 5 (month) 31 (day) 48 (year)

Cemetery or crematory: New Cathedral Cem.

Location: 4300 Old Frederick Road

18. Funeral director: Chas. Lowan & Son

Address: 96-98 Collins Street.

19. 5 29 19 48 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 48 at 8 10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 19 47, to May 28 19 48 and that I last saw h[illegible] alive on May 28 19 48

Immediate cause of death	DURATION
Cancer of Stomach	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bale Jr. M. D. or other

Address: Linthicum Date signed 5-28-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible entry is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1948
14
3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04632

CERTIFICATE OF DEATH 1948 Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Russel, Drury, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A.A.

City or town: Russel, Drury, Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1/4 mile east of Drury

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Josephine Ridgley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	L.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 20 Mar 48

8. AGE:

Years	Months	Days	If less than one day
	1	15	hrs. min.

9. Birthplace: Drury, A.A. Co. Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: Algernon Sidney Ridgley

13. Birthplace: Howard Co

MOTHER 14. Maiden name: Margie Josephine Ridgeley

15. Birthplace: Howard Co

16. Informant: Algernon L. Ridgley

Address: Lothian, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6 1948 (month) (day) (year)

Cemetery or crematory: Ant. Calvary

Location: Drury Md

18. Funeral director: E. C. Gaudette & Son

Address: Odenville Md.

19. 5 6 48 (Date rec'd by registrar) W. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 May 1948, at 2 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 May 1948, to 5 May 1948 and that I last saw h— alive on — 19—

	DURATION
Immediate cause of death: Pulmonary Edema	10 minutes
Due to: Aspiration gastric contents	10 min.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R B Jansen M.D. (M. D. or other)

Address: Upper Marlboro Md Date signed: 5 May 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

170C

04633

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Stoney Creek - P.O. Pasadena.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Two seconds.
Hospital, institution, or street address where death occurred: Stoney Creek Bridge.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3 - West Fourth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frederick Gerhardt Sanders, Jr.

3.(b) Social Security Number: 215-22-7792

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 11/17/1929

8. AGE: Years: 18 | Months: 5 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Anne Arundel County, Md. (Town, county, and state)
10. Usual occupation: Dairy Manager at
11. Industry or business: the A. & P. store. -

FATHER
12. Name: Frederick G. Sanders, Sr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Violet Mae Wicks
15. Birthplace: St. Marys County, Md.

16. Informant: Mr. F. G. Sanders, Sr. (father)
Address: P.O. Pasadena, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 5/7/48 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Frederick Ave.
18. Funeral director: John F. Kenny Inc. L.&E.
Address: 714 Light St.

19. 5/7 1948 (Date rec'd by registrar) A. H. Schaub Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1948 at 1.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19— to — 19—
and that I last saw h— alive on — 19—

	DURATION
Immediate cause of death: Accidental drowning.	Sudden
Due to: automobile accident. -	—
Due to: automobile falling off the	—
Other conditions: bridge into 20 feet of water.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 5/4/48
Where did injury occur? Co. Pasadena, A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Stoney Creek Bridge
Means of injury: Drowning. Injured at work? No

23. SIGNATURE: Gustave J. Fankenstein
Acting Deputy Medical Examiner
M. D. or Other
Address: Glen Burnie Md. Date signed: 5/4/48.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04634

Reg. Dist. No. 21

1. PLACE OF DEATH

County A.A. Co Md

City or town PASADENA

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs

Hospitnl, institution, or street address where denth occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A. A.

City or town PASADENA

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veterna, nnme war

3.(a) FULL NAME William Herbert Sappington

3.(b) Social Security Number 217-07-0998

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husbnnd or wife: Augusta C.

6.(c) If alive, give age ..... years

7. Birth dnte of decensed (mo., dny, yr.): August 22. 1897

8. AGE: Yenrs 50 | Months 8 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplnce: Elwaton Md

(Town, county, and state)

10. Usunl occupation: Retired Clerk, laborer & Mail carrier

11. Industry or business:

FATHER

12. Hnme: Greenberry Thomas

13. Birthplnce: Md

MOTHER

14. Maiden name: Mary E. Stallings

15. Birthplace: Md

16. Intermant: Augusta C. Sappington

Address: Pasadena Md

17. Burial, cremation, or removal. Which?: Burial Dnte thereof: May 11 - 1948 (month) (day) (year)

Cemetery or crematory: Glen Haven

Locnlion: A.A. Co Md

18. Funernl director: P.F.C. & B.M. Walters

Address: Pratt & Stricker Sts. Balto Md

19. (Dnte rec'd by registrar) May 10 19 48 — A.L. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 19 48, at 1 15 A.M.

21. I CERTIFY that denth occurred on the date nbove stated; thnt I nttended deceased from Jan. 19 44, to May 8 19 48

and thnt I lnst saw him nlive on May 6 19 48

	DURATION
Immediate cause of death: Pulmonary Hemorrhage	15 minutes
Due to: Pulmonary Tuberculosis.	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death shonld be charged statistically.

22. VIOLENCE: If death was due to external cnuses, fill in the following:

Accident, suicide, or homicide: Dnte of

Where did injury occur? (City or town) (County) (Stnte)

Injured nt home, fnrm, Industry, public place (where?)

Menns of injury: Injured at work?

23. SIGNATURE: James S. Beckingale M.D.

M. D. or other

Address: Glen Burnie Md Dnte signed: May 9, 1948

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

183 04635

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? dead on arrival
Hospital, Institution, or street address where death occurred: Emergency Hospital
How long in hospital or Institution? dead on arrival

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For residence of infants give residence of mother) Carroll
State Maryland County Frederick
City or town Thurmont
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Virginia Schaffer

3.(b) Social Security Number 216-01-4188

4. Sex female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Lemon Schaffer
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) May 21-1889
8. AGE: Years 58 | Months 11 | Days 26 | If less than one day ..... hrs. ..... min.
9. Birthplace Carroll Co (Town, county and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Clayton Bill
13. Birthplace Balto Co.

MOTHER
14. Maiden name Laura Bowers
15. Birthplace Penna

16. Informant Edgar Schaffer
Address 522 Beaufort Ave Baltimore
17. Burial (Burial, cremation, or removal) Which? Date thereof May 19-48 (month) (day) (year)
Cemetery or crematory Finksburg Cemetery
Location Carroll Co
18. Funeral director J. F. Eline & Sons
Address Reisterstown Md.
19. May 16 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 1948 about 2:45 A.M.
21. I CERTIFY that death occurred on the date above stated, ~~that I attended deceased from~~ Post Mortem Examination
~~and that I last saw him alive on~~ ..... 19.....

Immediate cause of death	DURATION
Drowning	Sudden
Due to Accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of May 16, 1948
Where did injury occur Severna Park (City or town) Anne Arundel (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Severna Park Road
Means of injury Drowning Injured at work? No

23. SIGNATURE John W. Caffey M.D. Deputy Medical Examiner M. D.
Address Annapolis Md. Date signed 5-16-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

04636

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S.Naval Hospital, Annapolis, Maryland

How long in hospital or institution? 4 hours 47 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 125 South Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert Washington SHARPS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Wife- Carrie Sharps

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 3 - 3 - 1890

8. AGE: Years	Months	Days	If less than one day
58	2	19	..... hrs. ..... min.

9. Birthplace: Annapolis, Anne Arundel, Maryland (Town, county, and state)

10. Usual occupation: Tailor Shop, USNA

11. Industry or business

FATHER 12. Name: Richard Sharps

13. Birthplace: Annapolis, Md.

MOTHER 14. Maiden name: Emma Henderson

15. Birthplace: Annapolis, Md.

16. Informant: Daughter-Verdell Smith

Address: 125 South St., Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 26 48 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Rest St.

18. Funeral director: William Reese

Address: 108 Washington St., Annapolis, Md.

19. May 24, 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 May 1948, at 8:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4PM 21 May 1948, to 8:47 PM 21 May 194

and that I last saw him alive on 21 May 1948 19 8

Immediate cause of death	DURATION
Respiratory and Circulatory failures	5 hrs ?
Due to: Hemorrhage, Subarachnoid	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James K.V. Wilson Lt.(jg)(MC) James K.V.WILSON, USN

M. D. or other

Address: U.S.Naval Hospital, Annapolis, Md. Date signed: 5-21-48

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04637

932

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Pk.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Severna Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MRS. HELEN MAY SHERMAN (ELLEN)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Benjamin Walter Sherman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23rd 1874

8. AGE:

Years	Months	Days	If less than one day
74	1	0	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: —

FATHER
12. Name: Richard Eaton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Matilda Sharp
15. Birthplace: Maryland

16. Informant: Arnold J. Tschantre
Address: Severna Pk. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/26/48 (month) (day) (year)
Cemetery or crematory: Cambridge Cemetery
Location: Cambridge, Md.

18. Funeral director: Le Compte Funeral Home
Address: Cambridge Md.

19. May 24 1948 L. A. Brett
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1948 at 11:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 1948 to MAY 1948 and that I last saw h[illegible] alive on MAY 22 1948

Immediate cause of death	DURATION
CONGESTIVE HEART FAILURE	
Due to: HYPERTENSIVE SCLEROTIC Heart DISEASE	
Due to: UNKNOWN	
Other conditions: NONE	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry F. Zangan MD (M. D. or other)
Address: Glen Burnie Date signed: May 25, 1948

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92b

04638

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel

City or town Bacons Chapel Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Bacons Near Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Nellie Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	colored	Married

6.(b) Name of husband or wife James Smith

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Nov. 28, 1903

8. AGE: Years	Months	Days	If less than one day
44	6	6	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business

FATHER 12. Name Edward Cooper

13. Birthplace Maryland Howard Co.

MOTHER 14. Maiden name Maria Williams

15. Birthplace Maryland Howard Co.

16. Informant Maria Williams

Address Laurel R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1948 (month) (day) (year)

Cemetery or crematory Bacon Chapel

Location Near Laurel

18. Funeral director Ridgely Selby

Address 401 Washington Ave Laurel Md

19. May 31 1948 (Date rec'd by registrar) Elara Kaslick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29 1948, at 1/4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/8/47 19 to May 29 1948

and that I last saw him alive on May 28 1948

Immediate cause of death	DURATION
Mitral Stenosis	5
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W B Edmonds M.D. or other

Address Laurel Md Date signed 6/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04639

CERTIFICATE OF DEATH 140b

Reg. Diat. No. 71

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 Months

Hospital, institution, or street address where death occurred:
Near Delmar Ave So. of Fifth Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)

Street No. Griffiths Farm Near Delmar Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MILDRED M. SPEAL

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James J. Speal

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): April 4, 1928

8. AGE: Years	Months	Days	If less than one day
20	1	12	..... hrs. ..... min.

9. Birthplace: Anne Arundel County, Maryland
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own Home

FATHER
12. Name: James J. Vacek
13. Birthplace: Czechoslovakia

MOTHER
14. Maiden name: Anna M. Brosh
15. Birthplace: Baltimore, Md.

16. Informant: Mrs. James J. Vecek
Address: Crain Highway, Severn, Md RED BOX 227

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 48 (month) (day) (year)

Cemetery or crematory: Glen Haven

Location: Glen Burnie, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. 5/17 1948 (Date rec'd by registrar) L. J. Dobbs Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1948 at 1.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1948, to May 16 1948

and that I last saw h... alive on 5/14/48 1948

Immediate cause of death	DURATION
Pulmonary Embolism	Sudden.
Due to Hemorrhage	?
Due to Miscarriage (accidental)	
of 4½ months.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Eustace W. Parker M.D.
M. D. or other

Address: Glen Burnie, Md. Date signed .....

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

04640

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: A A Co
City or town: Carrel Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A Co.
City or town: Carrel Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: —
(If rural, give LOCATION)
2.(a) If veteran, name war: No Vet.

3.(a) FULL NAME: Charles D Tucker

3.(b) Social Security Number: 213-12-6176

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 25, 1918

8. AGE: Years	Months	Days	If less than one day
30			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Martin's

FATHER
12. Name: Charles D. Tucker
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret Allen
15. Birthplace: Virginia

16. Informant: Mrs Margaret Tucker
Address: Carroll Beach

17. Burial (Burial, cremation, or removal? Which?) Date thereof: 5/26/48 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Ritchie Highway

18. Funeral director: Sun F. Hensley Inc.
Address: 715 Light St 730.

19. May 24 1948 A W. Hensley
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1948 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1948 to May 23 1948 and that I last saw h. alive on May 23 1948.

	DURATION
Immediate cause of death: Cardiac Failure	
Due to:	
Due to:	
Other conditions: Paralysis - Spinal Cord injury (Trauma)	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other
Address: Riviera Beach, Md. Date signed: 5/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Wed - 2:00 PM.

Funeral from A.M.E.

Interment in Cedar Hill

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

04641

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

at residence

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: A. A. Co.

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alice Tyler Turner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: George J. Turner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 2d 1876

8. AGE: Years	Months	Days	If less than one day
72	2	18	..... hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: —

FATHER — 12. Name: George G. Tyler

13. Birthplace: Bolto, Md.

MOTHER — 14. Maiden name: Sophia Gardeman

15. Birthplace: Balto, Md.

16. Informant: Mrs. Nelson T. Turner

Address: Wardour, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/48 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Md.

18. Funeral director: John R. Taylor

Address: Annapolis, Md.

19. May 22 1948 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1948 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to May 20 1948, and that I last saw h... alive on May 19 1948

Immediate cause of death	DURATION
Cardio Vascular Failure	Indefinite
Due to Coronary Thrombosis	Several attacks Past 2 years
Due to Arterial Hypertension	Several Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work? .....

23. SIGNATURE: J. Oliver Turner M. D. or other

Address: Annapolis Md. Date signed 5/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

04642

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or illegible entry is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Parole St., Parole, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Tyler

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mary Tyler
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 3/9/1858

8. AGE: Years	Months	Days	If less than one day
90	2	0	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Charles Tyler
13. Birthplace: Virginia
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Mary Tyler
Address: Parole St, Parole Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 (month) 12 (day) 48 (year)
Cemetery or crematory: Bodkins Hill
Location: West D.
18. Funeral director: William Reese II
Address: 108 Washington St.
19. May 11 19 48 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1948, at 5:00 P.M.
21. I CERTIFY that death occurred on the date above stated: ~~Was reported present from~~ Postmortem Examination
~~and that I last saw~~ alive on May 9, 1948

	DURATION
Immediate cause of death: Acute Cardiac failure	Sudden
Due to: Syncope	
Due to: Arteriosclerotic heart disease	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed 5/10/48

CERTIFICATE OF DEATH

183

Registered No. 04643

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Broadwater Beach, A. A. Co.
(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State UNKNOWN County
(c) City or town
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME UNKNOWN

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: M

5. Color or race: W

6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1895

8. AGE: Years 53 | Months | Days | If less than one day ... hr. ... min.

9. Birthplace
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden Name
15. Birthplace

16 (a) Informant
(b) Address

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 25, 1948 (month) (day) (year)
(c) Cemetery or crematory A. A. Co. Home
Location Edgewater, Maryland

18 (a) Funeral director T. A. Hardesty
(b) Address Galesville, Md.

19 (a) 5/26/48 (Date rec'd by registrar) (b) Balto. City Health Dept. Registrar

VS 151

MEDICAL CERTIFICATION

20. DATE OF DEATH May 15, 1948, at ? M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☒ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Drowning

Due to

Other Conditions
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☒ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found May 15, 1948 at 10 A. M.
(b) Where did injury occur? Found Broadwater Beach, A. A. Co.
(c) Did injury occur at home, on farm, industrial place, in public place? Harbor While at work? No
(d) Means of injury Found drowned

23. Signature George G. Merrill M.D.
Medical Examiner.
Date signed 5-17-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

848 04641

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos. 26 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 5 mos. 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 528 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: CARL EUGENE WASHINGTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	NEGRO	MARRIED

6.(b) Name of husband or wife: Carrie Washington
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1914

8. AGE: Years	Months	Days	If less than one day
34			..... hrs. ..... min.

9. Birthplace: Western Port, Maryland (Town, county, and state)
10. Usual occupation: General labor work
11. Industry or business: ---

FATHER
12. Name: Saul Washington
13. Birthplace: Petersburg, W. Virginia

MOTHER
14. Maiden name: Lillian Kate Cox
15. Birthplace: W. Virginia

16. Informant: Hospital Records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9, 1948 (month) (day) (year)
Cemetery or crematory: Petersburgh W. Va
Location: Cumberland Md
18. Funeral director: John E. Wolford
Address: 105 So. Liberty St.
19. 5/6 48 (Date rec'd by registrar) E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 48 at 9:40 a.m.

21. I CERTIFY that death occurred on ths date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Respiratory Failure	
Following Electro-shock Treatment	sudden death
Due to:	
Due to:	
Other conditions: Schizophrenia - Catatonic	
Type known to us since	11/10/47

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. .....
Hyperemia of Internal Organs
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 5/6/48
Where did injury occur? Crownsville State Hospital, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) hospital
Means of injury: Electro-shock treatment Injured at work?

23. SIGNATURE: John M. Claffy, M.D. Deputy Medical Examiner M. D. or other
Address: Annapolis, Md Date signed 5/6/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

014645

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 175 Green Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ada Gertrude Wikel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Elbert M. Wikel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 26th 1892

8. AGE: Years: 55 Months: 11 Days: 13 If less than one day: hrs. min.

9. Birthplace: Scot Depot W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Henry B. Charles
13. Birthplace: Missouri

MOTHER
14. Maiden name: Addie Eggleston
15. Birthplace: W. Virginia

16. Informant: Albert M. Wikel
Address: 175 Green St. Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/11/48 (month) (day) (year)
Cemetery or crematory: Meadowridge Cemetery
Location: Howard Co. Md.

18. Funeral director: John M. Tayler Jr.
Address: Annapolis Md.

19. May 11, 1948 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9th 1948, at 4:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1948, to May 9 1948, and that I last saw her alive on May 9 1948.

	DURATION
Immediate cause of death: Acute Dilatation of Heart	5 Minutes
Due to: Myocarditis Chr.	1 year
Due to:	
Other conditions: Bronchial Asthma	Several years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. L. Boone M. D. or other
Address: Annapolis Md. Date signed: 5-11-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

93e

04646

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 yrs.

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 14 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield

(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: EDWARD WILLIAMS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	married

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): (unknown) 1869

8. AGE:

Years	Months	Days	If less than one day
79			..... hrs. ..... min.

9. Birthplace: Somerset County, Maryland

(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ---

FATHER

12. Name: Charles Williams

13. Birthplace: Virginia

MOTHER

14. Maiden name: Cecelia Williams

15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-2-48 (month) (day) (year)

Cemetery or ~~cemetery~~ Hospital

Location: Crownsville Md

18. Funeral director: Supt. Hospital

Address: Crownsville Md

19. 6-2- 1948 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 19 48, at 10:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 41, to May 28 19 48

and that I last saw him alive on May 28 19 48

	DURATION
Immediate cause of death: Myocarditis	
known to us since	Jan. 1948
Due to:	
Due to:	
Other conditions: Senile Delusional Insanity	
known to us since	5/20/34

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) --- (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury --- Injured at work?

23. SIGNATURE: Jacob Marquardt M.D.

M. D. or other

Address: Crownsville, Maryland Date signed 5/28/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect or is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M